CASE ID: DEU7348315
{450A0A6A-694B-4F9B-AC93-C70895CB990A}

Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION
DISABILITY EVALUATION UNIT
605 W Santa Ana Blvd, Bldg 28 Suite 451
Santa Ana, Ca 92701
714/558-4121

STATE OF CALIFORNIA
ARNOLD SCHWARZENEGGER, Governor

CONSULTATIVE RATING DETERMINATION

Deion Sanders
DEU File No: H78790
Occupation : PROFESSIONAL FOOTBALL PLAYER
EAMS Case No: DEU7348315

WCAB #....:
Age at DOI: 32

Employee Representative:

Employer Representative:

*DR. MARIA LEYNES*QME*08/24/2010*

THIS REPORT RATES 0% FINAL PD.
****
*DR. MICHAEL WELLS*QME*07/15/2010*
*DR. KENNETH NUDLEMAN*QME*07/08/2010*
*DR. MICHAEL EINBUND*QME*07/08/2010*

11.03.02.00-2-[2]2-590G-3-3 PD (A)
13.01.00.99-1-[6]1-590J-2-2 PD (A)
13.03.00.00-16-[6]21-590J-31-30 PD (A)
13.04.00.00-5-[2]6-590J-11-10 PD (A)
13.06.00.00-5-[8]7-590I-11-10 PD (A)
15.01.01.00-8-[5]10-590J-16-15 PD (A)
15.03.01.00-13-[5]17-590J-26-25 PD (A)
16.02.01.00-1-[7]1-590J-2-2 PD (B)
16.02.01.00-1-[7]1-590J-2-2 PD (C)
16.03.01.00-1-[2]1-590J-2-2 PD (B)
16.03.01.00-1-[2]1-590J-2-2 PD (C)
16.05.04.00-5-[1]6-590I-9-8 PD (B)

16.05.04.00-7-[1]8-590I-12-11 PD (C)
17.03.03.00-3-[5]4-590J-8-7 PD (D)
17.03.03.00-4-[5]5-590J-9-8 PD (E)
1% WP ADD-ON INCLUDED FOR PAIN
17.05.03.00-3-[2]3-590J-6-6 PD (D)
17.05.03.00-4-[2]5-590J-9-8 PD (E)
1% WP ADD-ON INCLUDED FOR PAIN
17.07.03.00-6-[2]7-590J-12-11 PD (D)
17.07.03.00-9-[2]10-590J-16-15 PD (E)
1% WP ADD-ON INCLUDED FOR PAIN

B = 8 C 2 C 2 = 12 PD (A)
C = 11 C 2 C 2 = 15 PD (A)
D = 11 C 7 C 6 = 22 PD (A)
E = 15 C 8 C 8 = 28 PD (A)

A = 30 C 28 C 25 C 22 C 15 C 15 C 12 C 10 C 10 C 3 C 2 = 86 FINAL PD

Cecilia Mejia

November 22, 2010

Disability Evaluator

Date

DEU Form 230 (Rev 1-91) K16244

CASE ID: ADJ7348315
{C887BB4E-238D-484D-BB86-897F4673EAD5}

DOCUMENT SEPARATOR SHEET

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CASE ID: ADJ7348315
{C887BB4E-238D-484D-BB86-897F4673EAD5}

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

☐ Amended Application

RECEIVED
MAY 27 2010
DWC/WCAB
SANTA ANA

Case No.

[redacted]
SSN (Numbers Only)

Venue choice is based upon (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(e)(2) or (d).)

☑ County of principal place of business of employee's attorney (Lebor Code section 5501.5(a)(3) or (d).)

ANA
Select 3 - Letter Office Code For Piece/Venue of Hearing (From the Document Cover Sheet)

Injured Worker (Completion of this section is required)

DEION
First Name

MI

SANDERS
Last Name

[redacted]
Street Address/PO Box (Pleese leave blank spaces between numbers, nsmes or words)

Street Address2/PO Box (Please leave blenk speces between numbers, names or words)

International Address (Please leave blank speces between numbers, names or words)

PROSPER
City

TX
State

[redacted]
Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Cerrier ☐ Employer ☐ Lien Claimant

Name (Pleese leave blank spsces between numbers, names or words)

Street Address/PO Box (Pleese leave blank speces between numbers, nemes or words)

Street Address2/PO Box (Please leave blenk speces between numbers, nemes or words)

City

Stste

Zip Code

CASE ID: ADJ7348315
{C8A7BB4E-23AD-4A4D-BBA6-A97F4673EAD5}

Employer Information (Completion of this section is required)

☑ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

DALLAS COWBOYS
Employer Name (Please leave blank spaces between numbers, names or words)

ONE COWBOY PARKWAY
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

IRVING — City
TX — State
75063 — Zip Code

Insurance Carrier Information (If known and if applicable - include even if carrier is adjuated by claims administrator)

TRAVELERS / GULF
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 660281
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

DALLAS — City
TX — State
75266 — Zip Code

Claims Administrator Information (If known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City — State — Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born 08/09/1967 (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) FOOTBALL PLAYER (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

☐ specific injury _____ (Date of Injury: MM/DD/YYYY)

suffered a ,

☑ cumulative injury which began on 05/15/1995 (Start Date: MM/DD/YYYY) and ended on 01/09/2000 (End Date: MM/DD/YYYY)

The injury occurred at VARIOUS STADIUMS & PRACTICE FACILITIES
Street Address/PO Box - Please leave blank spaces between numbers, names or words

City — State — Zip Code

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(State which parts of the body were injured)

Body Part 1: 100 HEAD

Body Part 2: 200 NECK

Body Part 3: 398 UPPER EXT

Body Part 4: 519 LEG

Other Body Parts: 700 MULTIPLE

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

SUSTAINED INJURIES WHILE PLAYING FOOTBALL

3. Actual earnings at the time of injury:

Rate of Pay $ MAX ☐ Monthly ☐ Weekly ☐ Hourly

State value of tips, meals, lodging, or other advantages, regularly received $ TBD ☐ Monthly ☐ Weekly ☐ Hourly

Number of hours worked per week MAX

4. The injury caused disability as follows:

Last day off work due to injury: 01/09/2000 MM/DD/YYYY

First Period of Disability: Start Date TBD MM/DD/YYYY End Date TBD MM/DD/YYYY

Second Period of Disability: Start Date TBD MM/DD/YYYY End Date TBD MM/DD/YYYY

5. Compensation:

Compensation was paid: ☐ Yes ☑ No

Total paid: NONE

Weekly rate(s): N/A

Date of last payment: NONE MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury? ☑ Yes ☐ No

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7. Medical treatment:
Medical treatment was received: ☑ Yes ☐ No

All treatment was furnished by the Employer or Insurance Carrier: ☐ Yes ☑ No

Date of last treatment: UNKNOWN
MM/DD/YYYY

Other treatment was provided/paid by: UNKKNOWN
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim? ☐ Yes ☑ No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

Case Number 1

Case Number 2

Case Number 3

Case Number 4

9. This application is filed because of a disagreement regarding liability for:

- ☑ Temporary disability indemnity
- ☑ Reimbursement for medical expense
- ☑ Medical treatment
- ☑ Compensation at proper rate
- ☑ Permanent disability indemnity
- ☑ Rehabilitation
- ☑ Supplemental Job Displacement/Return to Work
- ☑ Other (Specify) BENEFIT LABOR CODE

CASE ID: ADJ7348315
03/25/2010 10:37 {CR87BB4E-238D-484D-BB86-897F4673EAD5}

Is the Applicant Represented? [✓] Yes [ ] No If "No", applicant is to sign and date below.

If "Yes", applicant's representative is to complete the following and is to sign and date below.

[✓] Law Firm/Attorney [ ] Non-Attorney Representative

NAMANNY BYRNE OWENS
Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

MEL T
Attorney/Representative First Name MI

OWENS
Attorney/Representative Last Name

24411 RIDGE ROUTE DRIVE SUITE 135
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LAGUNA HILLS CA 92653
City State Zip Code

Applicant Attorney/Representative Signature

Applicant Signature

Dated at LAGUNA HILLS, California
City

Date 3/24/10
MM/DD/YYYY